**Text from CMS MU Stage 2 proposed rule** [**http://www.ofr.gov/OFRUpload/OFRData/2012-04443\_PI.pdf**](http://www.ofr.gov/OFRUpload/OFRData/2012-04443_PI.pdf)

p. 44

“An office visit is defined as any billable visit that includes: (1) concurrent care or

transfer of care visits; (2) consultant visits; or (3) prolonged physician service without

direct, face-to-face patient contact (for example, telehealth). A consultant visit occurs

when a provider is asked to render an expert opinion/service for a specific condition or

problem by a referring provider. The visit does not have to be individually billable in

instances where multiple visits occur under one global fee. Transitions of care are the

movement of a patient from one setting of care (hospital, ambulatory primary care

practice, ambulatory specialty care practice, long-term care, home health, rehabilitation

facility) to another. Currently, the meaningful use measures that use transitions of care

require there to be a receiving provider of care to accept the information. Therefore, a

transition home without any expectation of follow-up care related to the care given in the

prior setting by another provider is not a transition of care for purpose of Stage 2

meaningful use measures as there is no provider recipient. A transition within one setting

of care does not qualify as a transition of care. Referrals are cases where one provider

refers a patient to another, but the referring provider maintains their care of the patient as

well. (Please note that a "referral" as defined here and elsewhere in this proposed rule is….”

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p. 62

In addition, we encourage public comment on the burden and ability of including

disability status for patients as part of the data collection for this objective. We believe

that the recording of disability status for certain patients can improve care coordination,

and so we are considering making the recording of disability status an option for

providers. We seek comment on the burden incorporating such an option would impose

on EHR vendors, as well as the burden that collection of this data might impose on EPs,

eligible hospitals, and CAHs. In addition, we request public comment on --(1) how to

define the concept "disability status" in this context; and (2) whether the option to collect

disability status for patients should be captured under the objective to record

demographics, or if another objective would be more appropriate.

Sue may be able to provide some insight on the consolidated CDA. Suggested we comment on the consolidated CDA part of the ONC Standards/Cert rule.

Make it a requirement if the person is admitted from an LTPAC setting where that data is already collected from the referring setting.

**Proposed Measure:** More than 80 percent of all unique patients seen by the EP or

admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21

or 23) during the EHR reporting period have demographics recorded as structured data.

**p. 104**

**Proposed Objective**: The EP, eligible hospital or CAH who receives a patient from

another setting of care or provider of care or believes an encounter is relevant should

perform medication reconciliation. …

We note that when conducting medication reconciliation during a transition of

care, the EP, eligible hospital or CAH that receives the patient into their care should

conduct the medication reconciliation. ….For the purposes of this objective, we propose to maintain the definition of a transition of care as the movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

pp. 107 -110

The feedback we have received from providers who have met Stage 1 meaningful

use requirements has convinced us that the exchange of key clinical information is most efficiently accomplished within the context of providing a summary of care record during transitions of care. Therefore, we are proposing to eliminate the objective for the exchange of key clinical information for Stage 2 and instead include such information as part of the summary of care when it is a part of the patient's electronic record.

In addition the HIT Policy Committee made two separate Stage 2 recommendations for EPs, eligible hospitals, and CAHs to record additional information-

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● Record care plan fields, including goals and instructions, for at least 10 percent of transitions of care; and

● Record team member, including primary care practitioner, for at least 10 percent of patients.

We believe that this information is best incorporated as required data within the summary of care record itself. Rather than implement two separate objectives and measures for these recommendations, we are establishing these as required fields along with the summary of care information listed later. …

We encourage EPs to develop the most robust care plan that is warranted by the situation. We also welcome comments on both our description of a care plan and whether a description is necessary for purpose of meaningful use.

All summary of care documents used to meet this objective must include the following:

● Patient name.

● Referring or transitioning provider's name and office contact information (EP only).

● Procedures.

● Relevant past diagnoses.

● Laboratory test results.

● Vital signs (height, weight, blood pressure, BMI, growth charts).

● Smoking status.

● Demographic information (preferred language, gender, race, ethnicity, date of birth).

● Care plan field, including goals and instructions, and

● Any additional known care team members beyond the referring or transitioning provider and the receiving provider.

In addition, eligible hospitals and CAHs would be required to include discharge instructions.

In addition, all summary of care documents used to meet this objective must include the following:

● An up-to-date problem list of current and active diagnoses.

● An active medication list, and

● An active medication allergy list.

We encourage all summary of care documents to contain the most recent and up-to-date information on all elements. In order for the summary of care document to count in the numerator of this objective, the EP or hospital must verify these three fields for problem list, medication list, and medication allergy list are not blank and include the most recent information known by the EP or hospital as of the time of generating the summary of care document. We define problem list as a list of current and active diagnoses. We solicit comment on whether the problem list should be extended to include, "when applicable, functional and cognitive limitations" or whether a separate list should be included for functional and cognitive limitations. We define an up-to-date problem list as a list populated with the most recent diagnoses known by the EP or hospital.

**Proposed Measures:** EPs, eligible hospitals, and CAHs must satisfy both measures in order to meet the objective:

The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 65 percent of transitions of care and referrals.

The EP, eligible hospital or CAH that transitions or refers their patient to another setting of care or provider of care electronically transmits a summary of care record using Certified EHR Technology to a recipient with no organizational affiliation and using a different Certified EHR Technology vendor than the sender for more than 10 percent of transitions of care and referrals.

-The Collaborative supports the intent of this rule to not exclude any provider to access to information, however we believe that the focus should be on getting the information/moving the information regardless of how or between which parties. We see standards-based exchange as being essential. Docs/providers should not be excluded because they’re not part of your system or because they’re using a different EHR platform. This is of particular concern for LTPAC providers because we are on different platforms and affiliated with many different organizations. *Is there a better measure than 10% of information going outside of the organization to another EHR vendor?*

See Stage 2 MU objectives on care summaries, care coordination, PH reporting (e.g., immunizations), advance directives : pp: 159, 160, 161, 162

pp. 170-171

In an effort to align the clinical quality measures used within the EHR Incentive Program with the goals of CMS and HHS, the National Quality Strategy, and the HITPC's recommendations, we have assessed all proposed measures against six domains based on the National Quality Strategy's six priorities, which were developed by the HITPC Workgroups, as follows:….

● Patient and Family Engagement. These are measures that reflect the potential to

improve patient-centered care and the quality of care delivered to patients. They emphasize the

importance of collecting patient-reported data and the ability to impact care at the individual

patient level as well as the population level through greater involvement of patients and families

in decision making, self care, activation, and understanding of their health condition and its

effective management.

● Patient Safety. These are measures that reflect the safe delivery of clinical services in

both hospital and ambulatory settings and include processes that would reduce harm to patients

and reduce burden of illness. These measures should enable longitudinal assessment of

condition-specific, patient-focused episodes of care.

● Care Coordination. These are measures that demonstrate appropriate and timely

sharing of information and coordination of clinical and preventive services among health

professionals in the care team and with patients, caregivers, and families in order to improve

appropriate and timely patient and care team communication.

● Population and Public Health. These are measures that reflect the use of clinical and

preventive services and achieve improvements in the health of the population served and are

especially focused on the leading causes of mortality. These are outcome-focused and have the

ability to achieve longitudinal measurement that will demonstrate improvement or lack of

improvement in the health of the US population.

● Efficient Use of Healthcare Resources. These are measures that reflect efforts to

significantly improve outcomes and reduce errors. These measures also impact and benefit a

large number of patients and emphasize the use of evidence to best manage high priority

conditions and determine appropriate use of healthcare resources.

● Clinical Processes/Effectiveness. These are measures that reflect clinical care

processes closely linked to outcomes based on evidence and practice guidelines.

pp. 176- 177

Per the preamble discussion in the Stage 1 final rule regarding measures gaps and

Medicaid providers (75 FR 44506), we are proposing to increase the total number of clinical

quality measures for EPs in order to cover areas noted by commenters such as behavioral health,

dental care, long-term care, special needs populations, and care coordination. The new measures

we are proposing beginning with CY 2014 include new pediatric measures, an obstetric measure,

behavioral/mental health measures, and measures related to HIV medical visits and antiretroviral

therapy, as well as other measures that address National Quality Strategy goals.

We recognize that we do not have additional measures to propose beginning with

CY 2014 in the areas of long-term and post-acute care. Since the publication of the Stage 1 final

rule, we have partnered with the National Governor's Association to participate in a panel

with long-term care and health information exchange experts to gain insight and consensus on

possible clinical quality measures. At this time, however, no clinical quality measures for

long-term and post-acute care have been identified as being ready (electronically specified)

beginning with CY 2014. We expect to continue to develop or identify clinical quality measures

for these areas with our partners and stakeholders for future years.

p.274

It is important to note that we would consider a hospital that changes its status from a

hospital (other than a CAH) that is excluded from the Medicare hospital inpatient prospective

payment system (IPPS) to a hospital that is subject to the IPPS to be a new hospital for purposes

of qualifying for this proposed exception. These IPPS-exempt hospitals, such as long-term care

hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities children's hospitals,

and cancer hospitals, are excluded from the definition of "eligible hospital" for purposes of the

Medicare EHR Incentive Program and have not necessarily had an opportunity to demonstrate

meaningful use.

p.282

On the other hand, other types of hospitals such as long-term care hospitals, psychiatric

hospitals, and inpatient rehabilitation facilities are not subsection (d) hospitals. These other

types of hospitals do not meet the definition of an "eligible hospital" for purposes of the

Medicare EHR hospital incentive payments and the application of the proposed hospital market

basket adjustment in FY 2015 and subsequent years under section 1886(n)(6)(B) of the Act.

pp. 109-110

We encourage all summary of care documents to contain the most recent and

up-to-date information on all elements. In order for the summary of care document to

count in the numerator of this objective, the EP or hospital must verify these three fields

for problem list, medication list, and medication allergy list are not blank and include the

most recent information known by the EP or hospital as of the time of generating the

summary of care document. We define problem list as a list of current and active

diagnoses. We solicit comment on whether the problem list should be extended to

include, "when applicable, functional and cognitive limitations" or whether a separate list

should be included for functional and cognitive limitations. We define an up-to-date

problem list as a list populated with the most recent diagnoses known by the EP or

hospital. We define active medication list as a list of medications that a given patient is

currently taking.

Shelly Spiro: Medication Reconciliation section

Comments from Pharmacy HIT Collaborative –

*We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription.  However, we encourage public comment on this assumption.*

If an EHR feeds the active medication list from eRX and medication history (claims based RX history) not from reconciled medication list outlined in the section from pages 104-105, then the active medication list (page 59 ***Consolidated Objective:  Maintain active medication list.)*** is produced from potentially two inaccurate electronic sources.  If OTC’s are excluded from the definition of prescriptions, then how will they be included in the active medication list?  We must begin to think about the work flow of the prescriber who will be writing for prescription including drug interaction alerts that will check for new prescriptions written against the active medication list.

In the LTPAC setting we must advocate to mandate that the active medication list received from EP and EH include all medication including non-prescription medications and supplements from a reconciled medication list hopefully produced by a pharmacist.  In addition, the active medication list in patient care or discharge summaries must also include the same.

**CMS-0044-P   104 -105**

***Proposed Objective****:* ***The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.***

*Medication reconciliation allows providers to confirm that the information they have on the patient's medication is accurate.  This not only assists the provider in their direct patient care, it also improves the accuracy of information they provide to others through health information exchange.*

*We note that when conducting medication reconciliation during a transition of care, the EP, eligible hospital or CAH that receives the patient into their care should conduct the medication reconciliation.  It is for the receiving provider that up-to-date medication information will be most crucial in order to make informed clinical judgments for patient care.  We reiterate that the measure of this objective does not dictate what information must be included in medication reconciliation.  Information included in the process of medication reconciliation is appropriately determined by the provider and patient.  For the purposes of this objective, we propose to maintain the definition of a transition of care as the movement of a patient from one setting of care (for example, a hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.  For Stage 2, we also propose to maintain the definition of medication reconciliation as the process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital or other provider.  There are additional resources available that further define medication reconciliation that while not incorporated into meaningful use may be helpful for EPs, eligible hospitals, and CAHs.  While we believe that an electronic exchange of information following the transition of care of a patient is the most efficient method of performing medication reconciliation, we also realize it is unlikely that an automated process within the EHR will fully supplant the medication reconciliation conducted between the provider and the patient.  Therefore, the electronic exchange of information is not a requirement for medication reconciliation.*

*While the objective is to conduct medication reconciliation at all relevant encounters, determining which encounters are relevant beyond transitions of care is too subjective to be included in the measure.*

**CMS-0044-P   53-59**

***Consolidated Objective:  Implement drug-drug and drug-allergy interaction checks.***

*For Stage 2, we are proposing to make the objective for "Implement drug-drug and drug-allergy checks" one of the measures of the core objective for "Use clinical decision support to improve performance on high-priority health conditions."  We continue to believe that automated drug-drug and drug-allergy checks provide important information to advise the provider's decisions in prescribing drugs to a patient. Because this functionality provides important clinical decision support that focuses on patient health and safety, we believe it is appropriate to include this functionality as part of the objective for using clinical decision support.*

***Proposed EP Objective:  Generate and transmit permissible prescriptions electronically***

***(eRx).***

*The use of electronic prescribing has several advantages over having the patient carry the prescription to the pharmacy or directly faxing a handwritten or typewritten prescription to the pharmacy.  When the EP generates the prescription electronically, Certified EHR Technology can recognize the information and can provide decision support to promote safety and quality in the form of adverse interactions and other treatment possibilities…….We do not believe that OTC medicines will be routinely electronically prescribed and propose to continue to exclude them from the definition of a prescription.  However, we encourage public comment on this assumption.*

***Consolidated Objective:  Maintain active medication list.***

Source: <http://www.ofr.gov/OFRUpload/OFRData/2012-04443_PI.pdf>

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Measure Number** | **Clinical Quality Measure Title & Description:** | **Clinical Quality Measure Steward & Contact Information:** | **Other Quality**  **Measure**  **Programs that**  **use the Same**  **Measure\*\*** | **New Measure** | **Domain** |
| p. 182 TBD | Title: Functional status assessment for complex chronic  conditions  Description: Percentage of patients aged 65 years and older  with heart failure and two or more high impact conditions who  completed initial and follow-up (patient-reported) functional  status assessments. | Title: Functional status assessment for complex chronic conditions  CMS 1-888-734-6433 or http://questions.cms.hhs.gov/app/ask/p/21,26,1139 |  |  | Patient and Family Engagement |
| p.191 NQF  0050 | Title: Osteoarthritis (OA): Function and Pain  Assessment  Description: Percentage of patient visits for  patients aged 21 years and older with a diagnosis  of OA with assessment for function and pain. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Patient and  Family  Engagement |
|  |  |  |  |  |  |
| p. 195 NQF  0097 | Title: Medication Reconciliation  Description: Percentage of patients aged 65  years and older discharged from any inpatient  facility (e.g. hospital, skilled nursing facility,  or rehabilitation facility) and seen within 60  days following discharge in the office by the  physician providing on-going care who had a  reconciliation of the discharge medications  with the current medication list in the medical  record documented. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | ACO, Group  Reporting  PQRS, NCQAPCMH  Accreditation | New | Patient Safety |
| p. 196 NQF  0101 | Title: Falls: Screening for Falls Risk  Description: Percentage of patients aged 65  years and older who were screened for future fall  risk (patients are considered at risk for future  falls if they have had 2 or more falls in the past  year or any fall with injury in the past year) at  least once within 12 months. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | PQRS, ACO,  Group  Reporting  PQRS | New | Patient Safety |
| p. 196 NQF  0103 | Title: Major Depressive Disorder (MDD):  Diagnostic Evaluation  Description: Percentage of patients aged 18  years and older with a new diagnosis or  recurrent episode of MDD who met the DSM-IV  criteria during the visit in which the new  diagnosis or recurrent episode was identified  during the measurement period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Clinical  Process/  Effectiveness |
| p. 196 NQF  0104 | Title: Major Depressive Disorder (MDD):  Suicide Risk Assessment  Description: Percentage of patients aged 18  years and older with a new diagnosis or  recurrent episode of MDD who had a suicide  risk assessment completed at each visit during  the measurement period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Clinical  Process/  Effectiveness |
| p. 196 NQF  0105 | Title: Anti-depressant Medication  Management: (a) Effective Acute Phase  Treatment, (b)Effective Continuation Phase  Treatment  Description: The percentage of patients 18 years  of age and older who were diagnosed with a new  episode of major depression, treated with  antidepressant medication, and who remained on  an antidepressant medication treatment. | NCQA  Contact  Information:  www.ncqa.org | EHR PQRS,  HEDIS, State  use, ACA 2701 |  | Clinical  Process/  Effectiveness |
| Also see pp. 197=198,202, 205- 206 for other BH/MH measures | | | | | |
|  |  |  |  |  |  |
| p. 199 NQF  0322 | Title: Back Pain: Initial Visit  Description: The percentage of patients with a  diagnosis of back pain who have medical  record documentation of all of the following on  the date of the initial visit to the physician:  1. Pain assessment  2. Functional status  3. Patient history, including notation of  presence or absence of "red flags"  4. Assessment of prior treatment and response,  and  5. Employment status | NCQA  Contact  Information:  www.ncqa.org | PQRS | New | Efficient Use  of Healthcare  Resources |
|  |  |  |  |  |  |
| p. 207 TBD | Title: Falls: Risk Assessment for Falls  Description: Percentage of patients aged 65  years and older with a history of falls who had a  risk assessment for falls completed within 12  months. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | PQRS | New Patient | Safety |
| p. 207 TBD | Title: Falls: Plan of Care for Falls  Description: Percentage of patients aged 65  years and older with a history of falls who had a  plan of care for falls documented within 12  months. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | PQRS | New | Patient Safety |
| p. 208 TBD | Title: Chronic Wound Care: Use of wet to dry  dressings in patients with chronic skin ulcers  (overuse measure)  Description: Percentage of patient visits for  those patients aged 18 years and older with a  diagnosis of chronic skin ulcer without a  prescription or recommendation to use wet to  dry dressings. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | PQRS | New | Patient Safety |
| p. 208 TBD | Title: Dementia: Staging of Dementia  Description: Percentage of patients, regardless of  age, with a diagnosis of dementia whose severity  of dementia was classified as mild, moderate, or  severe at least once within a 12 month period | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Clinical  Process/  Effectiveness |
| p. 208 TBD | Title: Dementia: Cognitive Assessment  Description: Percentage of patients, regardless  of age, with a diagnosis of dementia for whom  an assessment of cognition is performed and the  results reviewed at least once within a 12 month  period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Clinical  Process/  Effectiveness |
| p. 208  TBD | Title: Dementia: Functional Status Assessment  Description: Percentage of patients, regardless  of age, with a diagnosis of dementia for whom  an assessment of functional status is performed  and the results reviewed at least once within a 12  month period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Clinical  Process/  Effectiveness |
| p. 209 TBD | Title: Dementia: Counseling Regarding Safety  Concerns  Description: Percentage of patients, regardless  of age, with a diagnosis of dementia or their  caregiver(s) who were counseled or referred for  counseling regarding safety concerns within a 12  month period | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Patient and  Family  Engagement |
| p. 209 TBD | Title: Dementia: Counseling Regarding Risks of  Driving  Description: Percentage of patients, regardless  of age, with a diagnosis of dementia or their  caregiver(s) who were counseled regarding the  risks of driving and the alternatives to driving at  least once within a 12 month period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org | PQRS | New | Patient Safety |
| p. 209 TBD | Title: Dementia: Caregiver Education and  Support  Description: Percentage of patients, regardless  of age, with a diagnosis of dementia whose  caregiver(s) were provided with education on  dementia disease management and health  behavior changes AND referred to additional  resources for support within a 12-month period | AMA-PCPI  Contact  Information:  cpe@amaassn.  org |  | New | Patient and  Family  Engagement |
| p. 209 TBD | Title: Chronic Wound Care: Patient education  regarding long term compression therapy  Description: Percentage of patients aged 18  years and older with a diagnosis of venous ulcer  who received education regarding the need for  long term compression therapy including  interval replacement of compression stockings  within the 12 month reporting period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  Org;  NCQA  Contact  Information:  www.ncqa.org | PQRS | New | Patient and  Family  Engagement |
| p. 209 TBD | Title: Rheumatoid Arthritis (RA): Functional  Status Assessment  Description: Percentage of patients aged 18  years and older with a diagnosis of RA for  whom a functional status assessment was  performed at least once within 12 months. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org | PQRS | New | Patient and  Family  Engagement |
| p. 210 TBD | Title: Chronic Wound Care: Patient Education  regarding diabetic foot care.  Description: Percentage of patients aged 18  years and older with a diagnosis of diabetes and  foot ulcer who received education regarding  appropriate foot care AND daily inspection of  the feet within the 12 month reporting period. | AMA-PCPI  Contact  Information:  cpe@amaassn.  org;  NCQA  Contact  Information:  www.ncqa.org |  | New | Patient and  Family  Engagement |
| p. 210 TBD | Title: Closing the referral loop: receipt of  specialist report  Description: Percentage of patients regardless of  age with a referral from a primary care provider  for whom a report from the provider to whom  the patient was referred was received by the  referring provider. | CMS  1-888-734-6433  or  http://questions.c  ms.hhs.gov/app/  ask/p/21,26,113  9 |  | New | Care  Coordination |
| p. 210 TBD | Title: Functional status assessment for knee  replacement  Description: Percentage of patients aged 18  years and older with primary total knee  arthroplasty (TKA) who completed baseline and  follow-up (patient-reported) functional status  assessments. | CMS  1-888-734-6433  or  http://questions.c  ms.hhs.gov/app/  ask/p/21,26,113  9 |  | New | Care  Coordination |
| p. 210 TBD | Title: Functional status assessment for hip  replacement  Description: Percentage of patients aged 18  years and older with primary total hip  arthroplasty (THA) who completed baseline and  follow-up (patient-reported) functional status  assessments. | CMS  1-888-734-6433  or  http://questions.c  ms.hhs.gov/app/  ask/p/21,26,113  9 |  | New | Care  Coordination |
| p. 210 TBD | Title: Functional status assessment for complex  chronic conditions  Description: Percentage of patients aged 65  years and older with heart failure and two or  more high impact conditions who completed  initial and follow-up (patient-reported)  functional status assessments. | CMS  1-888-734-6433  or  http://questions.c  ms.hhs.gov/app/  ask/p/21,26,113  9 |  | New | Care  Coordination |

Table 17 (p. 330) provides burden estimate for reporting measures.

MAJD-Additional items worth looking into providing comments:

P. 151

**Proposed Eligible Hospital/CAH Objective**: Record whether a patient 65 years old or older has an advance directive.

The HIT Policy Committee recommended making this a core objective and also

requiring eligible hospitals and CAHs to either store an electronic copy of the advance CMS-0044-P 150 directive in the Certified EHR Technology or link to an electronic copy of the advance directive. However, we propose to maintain this objective as part of the Menu Set and we are not proposing a copy or link to the advance directive for eligible hospitals and CAHs in Stage 2. As we stated in our Stage 1 final rule (75 FR 44345), we have continuing concerns that there are potential conflicts between storing advance directives

and existing State laws. Also, we believe that because of State law restrictions, an advance directive stored in an EHR may not be actionable. Finally, we believe that eligible hospitals and CAHs may have other methods of satisfying the intent of this objective at this time, although we recognize that these workflows may change as EHR technology develops and becomes more widely adopted. Therefore, we do not propose to adopt the HIT Policy Committee's recommendations to require this objective as a core measure, to store an electronic copy of the advance directive in the Certified EHR Technology, or to link to an electronic copy of the advance directive.

The HIT Policy Committee has also recommended the inclusion of this objective

for EPs in Stage 2. In our Stage 1 final rule (75 FR 44345), we indicated our belief that many EPs would not record this information under current standards of practice and would only require information about a patient's advance directive in rare circumstances.

We continue to believe this is the case and that creating a list of specialties or types of EPs that would be excluded from the objective would be too cumbersome and still might not be comprehensive. Therefore, we are not proposing the recording of the existence of advance directives as an objective for EPs in Stage 2. However, we invite public comment on this decision and encourage commenters to address specific concerns regarding scope of practice and ease of compliance for EPs. And we note that nothing in this rule compels the use of advance directives.